STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	06/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 17, 18, 19, 20, 21, and 22, 2013 Facility Number: 000124 Provider Number: 155219 AIM Number: 100266730 Survey Team: Shauna Carlson, RN - TC Julie Baumgartner, RN Shelly Vice, RN Sharon Ewing, RN Census Bed Type: SNF/NF: 96 Total: 96 Census Payor Type: Medicare: 8 Medicaid: 67 Other: 21 Total: 96 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on June 30, 2013 by Brenda Meredith, R.N.	F000000	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. **This facility requests a desk review for paper compliance for all**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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			citations.	

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F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the resident, the resident's physician and the interested family member for 1 of 2 resident records reviewed.	F000157	F-157 Notification of Changes I. How corrective action will be accomplished for those affected. Physician and responsible party	07/22/2013

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	(Resident #6) Findings include: On 6-20-2013 at 2:55 P.M., record review for Resident # 6 indicated the resident had a significant weight loss of 6.6% in the last 30 days. Resident #6 was placed on weekly weights on 6-7-2013. Resident #6 clinical record did not have any documentation of notification to the physician or responsible family member. On 6-20-2013 at 3:25 P.M., interview with the DON (Director of Nursing) indicated the RD (Registered Dietician) informs the DON and the UM (Unit Manager) of the significant weight losses and the nurses are responsible for notification to the physician and family. On 6-21-2013 at 8:45 A.M., interview with RD indicated that Resident #6 had a significant weight loss in 30 days after she was weighed on 6-7-2013. The RD then indicated she began weekly weights on the resident. The RD indicated that she added Resident #6 to the "Medical Nutrition Therapy Recommendation Log," a tool that she uses to communicate with the DON, ED (Executive Director), and UM on		and resident #6 were notified of significant weight loss on 7/2/13. II. How corrective action will be accomplished for those residents having potential to be affected. All other residents with significant weight loss have the potential to be affected. III. What measures will be put in place/systemic changes made to ensure correction. Licensed nurses have been inserviced on Policy and Procedure for Physician and Family Notification of significant change of condition. Dietitian will complete Nutritional Consultant Report weekly which addresses residents with significant weight loss or gain and any recommendations. DNS or Designee will notify all Physician, family and resident of significant weight loss weekly. IV. What measures will be put in place/systemic changes made to ensure correction. DNS or Designee will review Nutritional Consultant Report weekly for significant weight changes.	

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	6-7-2013. On 6-21-2013 at 2:40 P.M., interview with the UM indicated that she did not receive the notice of significant weight loss for Resident #6. UM presented and review was made of the "Medical Nutrition Therapy Recommendation Log" which indicated Resident #6 was not listed on the 6-7-2013 form. UM indicated that she receives the "Medical Nutrition Therapy Recommendation Log" twice a week from the RD and notifies the physician about the concerns and/or recommendations, if any. UM indicated the nursing staff then finish the physician order, if any, and notify the family. Review of the "Progress Notes," specifically "Nutrition Services Visit Note," indicated no notes had been made for the month of May 2013, or the month of June 2013, related to significant weight loss or notification of significant weight loss until June 21, 2013 at 12:10 P.M. by the RD. 3.1-5(a)(2)		Reports will be reviewed in Performance Improvement Meeting monthly x 6 months. Systemic changes will be completed by July 22, 2013	

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F000164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. 1. Based on observation, interview and record review, the facility failed to provide privacy during personal care for Resident #105. This deficiency affected 1 of 40 residents sampled. 2. Based on observation and interview, the facility failed to provide	F000164	F- 164 Personal Privacy and Confidentiality of Records I. How corrective action will be accomplished for those affected. Resident #105 was moved back to his original room, the privacy	07/22/2013

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	privacy during doctor exam visits. This deficiency affected 1 of 29 Residents being seen by Doctor #10; and 1 of 1 Residents seen by Doctor #11. (Resident #62) Findings included: 1. On 6/17/2013 at 9:00 p.m., an observation was made of Resident #105 in his room. Resident #105's roommate was present at this time. The personal care of Resident #105 was being conducted. The resident was incontinent and laying sideways in his bed with his disposable undergarment untaped and his hands underneath the garment. The room smelled of urine. There was not a privacy curtain available to separate the two residents. The curtain was completely missing. CNA #5 indicated the privacy curtain was missing and could not provide privacy during the pericare and changing of Resident #105. On 6/21/13 at 2:30 p.m., an interview was conducted with the Maintenance man indicating the responsibility for placing the curtain track hardware and the hanging clip hardware was of the maintenance department. On 6/21/13 at 2:35 p.m., an interview		curtains are intact and in place. Resident #62 is not identified in the sample. Certified Nursing Assisant #5, Doctor #10, and #11 have been reeducated on provision of privacy during care. II. How corrective action will be accomplished for those residents having potential to be affected.. Nursing department has been inserviced on Privacy and Confidentiality. All Privacy curtains are in place in resident rooms. All interviewable residents will be interviewed r/t lack of provision of privacy. III. What measures will be put in place/systemic changes made to ensure correction. The Service provider for Audiology, Podiatry, Optometry, and Dental, have been inserviced on privacy and closing door while providing services. Medical Director inserviced on Privacy Policy related to physician services. Angel Care Checklist to be completed on 10 residents weekly by Guardian Angels to ensure privacy curtains are present, clean in good repair, and that privacy is being provided during	

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	was conducted with the Housekeeping and Laundry Supervisor indicating that the privacy curtains were taken down and replaced by their department. On 6/21/13 at 2:40 p.m., an interview was conducted with the Administrator indicating that the room of concern had been a temporary location for both Resident #105 and Resident #56 for maintenance work of their original room. It was indicated that prior to this, the room of concern had been inhabited by one resident and had not required two privacy curtains. It was indicated that there should have been two privacy curtains for two residents occupying the same shared room. On 6/21/13 at 4:51 p.m., the Director of Nursing provided the Policy and Procedure titled, "Privacy Curtain and Drapery Maintenance." It indicated, "...Drapery Maintenance...7. If the room is occupied and the draperies must be removed for deep cleaning, put temporary replacements to protect the resident's privacy...." On 6/21/13 at 4:30 p.m., a record review was conducted of the Policy and Procedure titled, "General Environmental Conditions... 10. Patient rooms are designed or		care. IV. How the facility plans to monitor its performance to make sure that solutions are sustained. DNS or designee will review angel checklists monthly x 6 months in the Performance Improvement Meeting. Systemic changes will be completed by July 22, 2013	

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	equipped assure full visual privacy for each patient. Each bed has ceiling-suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. 2A. On 6/19/13 at 10:00 a.m. an observation was made of a doctors audiology exam being conducted on Resident #62 in the Beauty Shop of the facility with no provision for privacy. The Beauty Shop door was opened wide and the resident could be visualized from the hallway. Doctor #10 was overheard to explain the procedure of having an ear exam. The Doctor #10 was seen holding an otoscope in his left hand and his right hand to be on the Residents left ear. An interview was conducted at 10:05 a.m., with Doctor #10 indicating that the door should have been closed to provide privacy during the hearing exam for Resident #62. On 6/19/13 at 10:52 a.m., an interview was conducted with the Director of Nursing indicating that the Audiologist used the Beauty Shop for the residents exams. "...it's where they've done it ever since I've been here...."			

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	On 6/19/13 at 11:10 a.m., an interview was conducted with the Clinical Assistant of Doctor #10 indicating that her understanding was that the Beauty Shop was the only place the facility had offered the Audiology service to conduct the hearing and ear exams for the Residents. On 6/21/13 at 3:00 p.m., an interview was conducted with the Administrator indicating that the door should have been closed to provide privacy for Resident #62 during the doctors visit and exam. 2B. On 6/19/13 at 11:50 p.m., an observation was made of the Unit Manager compiling resident charts from the North Hall. An interview conducted with Employee #8 indicated, "... it's Dr.(name) exam day.... he's doing rounds on the residents...." On 6/19/13 at 12:10 p.m., an observation was made of Doctor #11 providing a personal exam of Resident #62. Resident #62 was in his wheelchair and parked by the nurses station during the lunchtime hour. Multiple staff, residents and family members were walking throughout the pathway. There was			

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	no provision for privacy in this situation. Doctor #11 inquired of Resident #62's name, greeted him by name, asked how the resident was,"...getting along...," listened to Resident #62's front chest, touched his arm and left. Doctor #11 was escorted by Employee #3. On 6/19/13 at 12:15 p.m., an interview was conducted with Employee #8 indicating that,"...that's Dr. (name), he's doing their check-ups...." On 6/21/13 at 3:05 p.m., an interview was conducted with the Administrator indicating that the Doctors are not to visit and or exam a Resident without providing privacy first. 3.1-3(p)(2) 3.1-3(p)(4)			

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F000241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to ensure 1 of 8 residents observed for care was concealed during peri-care by a privacy curtain in order to maintain his dignity. (Resident #105) Findings include: On 6/17/13 at 9:15 PM, during an observation of 2 CNA's entering Resident #105's room for care showed there was no privacy curtain between Resident #105 and his roommate. CNA #5 indicated at this time, "...Oh, there's no privacy curtain in here?" CNA #5 then proceeded to close the door to the room and pull the privacy curtain between Resident #105 and the door but failed to take any measure to protect Resident #105 from his roommates view. Resident #105 was laying in bed #1 (closer to the door) with blankets off, gown pulled up, and depend brief on and visibly soiled. Both CNA's proceeded to clean and change Resident #105 in full view of the	F000241	F 241 Dignity and Respect of Individuality I. How corrective action will be accomplished for those residents having potential to be affected. Resident #105's room has a privacy curtain that will ensure he is afforded full visual privacy during personal care II. How corrective action will be accomplished for those residents having potential to be affected. All residents have the potential to be affected. Angel care rounds will ensure privacy curtains are present, clean and in good repair for all resident rooms. III. What measures will be put in place/systemic changes made to ensure correction. Nursing department has been inserviced on Privacy and Confidentiality, specifically that privacy curtains are in place and	07/22/2013

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	roommate. On 6/20/13 at 3:40 PM, record review of Resident #105's chart indicated his diagnoses included but were not limited to "...dementia with behavioral disturbances, traumatic fracture of the hip, anxiety, depressive d/o [disorder]...." On 6/20/13 at 5:00 PM, interview with the Executive Director indicated that Resident #105 and Resident #56 were in their current room temporarily so repairs could be done on their permanent room. The Executive Director further indicated there should have been a privacy curtain placed between the two residents before they were moved to the temporary room. 3.1-3(t)		utilized. All Privacy curtains are in place in resident rooms. Angel Care Checklist to be completed on 10 residents weekly by Guardian Angels to ensure privacy curtains are present, clean and in good repair and privacy is afforded during care. IV. How the facility plans to monitor its performance to make sure that solutions are sustained. DNS or designee will review Angel Care Checklist monthly x 6 months in Performance Improvement Meeting. Systemic changes will be completed by July 22, 2013	

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F000253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure the cleanliness of pullcords in resident bathrooms or clean the metal grab bars located by the toilet in the resident bathrooms. This deficiency affected 14 of 40 resident bathrooms. Findings included: 1. On 6/18/13 between the hours of 9:30 a.m. and 10:30 a.m. a tour was conducted of the South Hall resident rooms of the facility. An observation was conducted of the condition of the following rooms: Room #103, #104, #107, #108, #109, #111, # 113, #117, #118, #119, #129, #130, #131, and #132. This indicated that the bathroom call light string pull cords were discolored with brown and yellow. On 6/21/13 at 9:00 a.m., an observation was made of Employee #12 cleaning room #131 indicating that the pull cord to the bathroom call light was not cleaned. On 6/21/13 at 3:20 p.m., an interview	F000253	F 253- I. How corrective action will be accomplished for those affected. Rooms 103, 104 107. 108, 109, 111, 113, 117, 118, 119, 129, 130, 131, and 132, Grab bars and Pull cords will be cleaned or replaced as necessary to comply with regulatory guidelines. II. How corrective action will be accomplished for those residents having potential to be affected. All residents have the potential to be affected. The Environmental Services Supervisor and Maintenance Supervisor or designee will make environmental rounds of resident bathrooms to ensure grab bars and pull cords are clean. III. What measures will be put in place/systemic changes made to ensure correction. The Environmental Services Supervisor and Maintenance Supervisor or designee will make environmental rounds 2x weekly of resident rooms and common areas to assure the grab bars/pull cords are clean and in good repair. The Environmental Supervisor and Maintenance Supervisor or designee will inservice the environmental staff on grab bar and pull cord cleaning/replacement. The SDC or designee will inservice	07/22/2013

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	was conducted with the Housekeeping and Laundry Supervisor indicating that the pull cords were cleaned daily by the housekeepers. It was noted this task was a part of the routine cleaning of the residents bathrooms. On 6/21/13 at 3:30 p.m., a request for the routine cleaning schedule for the housekeepers in regard to the cleaning of the call light pull cord was requested of the Housekeeping Supervisor. It was not provided. 2. On 6/18/13 between the hours of 9:30 a.m. and 10:30 a.m., a tour was conducted of the South Hall resident rooms of the facility. An observation was conducted of the condition of the following rooms: Room #103, #104, #107, #108, #109, #111, # 113, #117, #118, #119, #129, #130, #131, and #132. This indicated that the metal grab bars located by the toilet in the resident bathrooms had build up indicating uncleanliness of the the surface. It was observed upon feeling the surface texture of the smooth metal, to have a bumpy surface indicating the surface was not clean. On 6/21/13 at 9:00 a.m., an observation was made of Employee #12 cleaning room #131 indicating		housekeeping staff on grab bar and pull cord cleaning and replacement. Repair requisitions are included in orientation of new hires. IV. How the facility plans to monitor its performance to make sure that solutions are sustained. The ED or designee will monitor through environmental rounds weekly to assure that the grab bars and pull cords are clean and in good repair. The data will be reviewed and analyzed monthly x 6 months at the Performance Improvement Committee Meeting. Systemic changes will be completed by July 22, 2013	

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	155219	A. BUILDING 00 B. WING	06/22/2013

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	the top surface of the grab bar was cleaned yet the underside was not. On 6/21/13 at 3:20 p.m., an interview was conducted with the Housekeeping and Laundry Supervisor indicating that the grab bars in the resident bathrooms by the toilets were routinely cleaned daily by the housekeepers. Upon feeling the underside of the metal surface, the Housekeeping/ Laundry supervisor frowned and noted,"... no that is not clean... I can feel it too...." On 6/21/13 at 3:30 p.m., a request for the routine cleaning schedule for the housekeepers in regard to the cleaning of the metal grab bars in the residents bathroom was requested of the Housekeeping Supervisor. It was not provided. 3.1-19(f)			

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F000256 SS=C	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. Based on observation and interview, the facility failed to provide bright lighting in the residents bathrooms. This affected 11 of 11 rooms sampled. (Rooms 108, 109, 118, 131, 104, 107, 111, 117, 103, 113, and 112) Findings included: On 6/18/13 at 10:00 a.m., an observation was made of the following resident rooms bathrooms for proper lighting levels: Rooms 108, 109, 118, 131, 104, 107, 111, 117, 103, 113, and 112. It was observed that the lighting in the residents bathrooms to have been very dim. On 6/19/13 at 10:15 a.m., an interview was conducted with the resident in room #107 indicating the bathroom lighting was dimly lit and had always been this way from his viewpoint. On 6/19/13 at 10:25 a.m., an interview was conducted with the resident in room #113 indicating the bathroom lighting was dimly lit.	F000256	F-256 Adequate and Comfortable Lighting Levels- I. How corrective action will be accomplished for those affected? Rooms 108, 109, 118, 131, 104, 107, 111, 117, 103, 113 and 112. The lighting in these rooms will be evaluated by maintenance department and adjustments will be made either by changing bulbs or changing fixture coverings to ensure adequate lighting in bathroom areas. II. How corrective action will be accomplished for those residents having potential to be affected. Lighting in all bathrooms will be measured for compliance with changes made as needed. III. What measures will be put in place/systemic changes made to ensure correction. Maintenance/housekeeping supervisor will be educated on requirements for bathroom lighting and making corrections as needed. Maintenance or housekeeping supervisors will make rounds weekly to ensure lighting is adequate in bathrooms. IV. How the facility plans to monitor its performance to make sure that solutions are sustained. Maintenance/housekeeping supervisor will make rounds to ensure lighting is adequate in bathrooms. Audit Tool to be	07/22/2013

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	On 6/20/13 at 3:00 p.m., an interview was conducted with a family member of the resident in room #104 indicating that the bathroom lighting should be brighter. On 6/21/13 at 3:00 p.m., an observation was conducted with the Maintenance Supervisor indicating that the current wattage of the light bulbs for the over the sink resident bathroom lighting was not to conserve energy and were not special light bulbs requested of the residents and or families. On 6/21/13 at 3:01 p.m., an interview was conducted with the Housekeeping and Laundry Supervisor indicating that the lighting appeared to be dim and would be better if brighter for the residents, the care giving staff and the families/ visitors. On 6/22/13 at 4:00 p.m., a record review was conducted of the Policy and Procedure titled," General Environmental Conditions...5. Adequate and comfortable lighting levels are provided...a. Sufficient lighting with minimum glare in areas frequented by patients; ...." 3.1-19(dd)		reviewed in Performance Improvement Meeting monthly x 6 months. Systemic changes will be completed by July 22, 2013	

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F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to revise and update the care plan to reduce the risk of future accident for 2 of 2 residents. (Resident #105 and Resident #48) Findings include: 1. On 6/19/13 at 9:42 AM, interview with LPN #15 indicated Resident #105 had sustained a fall on 5/26/13 with no reported injury. On 6/21/13 at 10 AM, record review of Resident #105's chart indicated his diagnoses included but were not	F000280	F280- Right to Participate Planning Care-Revise CP I. How corrective action will be accomplished for those affected? Residents #105 and #48 care plans have been updated and revised with interventions to reduce the risk of future accidents. II. How corrective action will be accomplished for those residents having potential to be affected. All residents with a care plan to reduce the risk of future accidents have the potential to be affected.	07/22/2013

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	limited to "...closed fracture of neck, diabetes type 2, htn [hypertension - high blood pressure], cerebrovascular disease, dementia with behavioral disturbances, traumatic fracture of the hip, anxiety, depressive d/o...." Review at this time of nurses notes for Resident #105 indicated "...5/26/13 07:17...Res [resident] found on floor...CNA [Certified nurses aide] reports res on floor, upon observation, res has fallen or slid out of bed with air mattress onto fall mat on floor directly in front of bed. Res positioned sitting upright on buttocks with legs in front of him. Tag alarm still attached to the resident upon falling...." On 6/21/13 at 11:00 AM, review of Resident #105's current care plans, received from the DON at this time, indicated "...Res [Resident] is High risk for falls r/t [related to] confusion, gait/balance problems, diminished safety awareness, history of falls...Interventions:...Fall matt [sic] at bedside, and low bed...date initiated: 4/11/2013...Follow facility fall protocol...date initiated 4/11/2013...Res uses tab alarm in bed, ensure the device is in place as needed...date initiated 10/15/2013...revision on:		These residents' care plans will be updated & revised. III. What measures will be put in place/systemic changes made to ensure correction. Nurses and the interdisciplinary team have been inserviced on revising and updating care plans. Care plans are reviewed by IDT at least quarterly and with significant change in condition. IDT will review all new admissions and residents with accidents to ensure appropriate care planning in clinical meeting 5x/wk. IV. How the facility plans to monitor its performance to make sure that solutions are sustained. DNS or Designee will review logs of care plan revisions monthly in the Performance Improvement Meeting X 6 months. Systemic changes will be completed by July 22, 2013	

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	4/10/2013...Resident has low air loss mattress, staff not to unplug the bed, causing to deflate, putting resident at risk for fall...date initiated: 5/17/2013...." 2. On 6/20/13 at 10:30 AM, record review of Resident #48's chart indicated his diagnoses included but were not limited to "...cellulitis and abscess of leg...pressure ulcer heel, pressure ulcer lower back,...hypertension, atrial fibrillation, chronic airway obstruction, contracture of hand joint, aphasia, traumatic amp [amputation] leg,...." On 6/21/13 at 10:40 AM, review of "Post fall evaluation Part 1" for Resident #48 indicated "...5/3/13...witnessed fall...description of fall: res to res altercation, roommate flipped him out of chair...activity at time of fall: sitting in w/c [wheelchair]...." On 6/21/13 at 10:55 AM, interview with LPN #8 indicated Resident #48 and Resident #50 had previously been roommates before the incident listed above and Resident #50 had become frustrated with Resident #48 and grabbed the front of his wheelchair and succeeded in tipping him over backwards. LPN #8			

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	indicated Resident #48 had acquired a new skin tear during this fall. Review at this time of the "Weekly non-pressure skin condition report" indicated "...Is this a new non-pressure area?...yes...date of first observance: 5/3/13...site: left forearm...skin tear...size in CM [centimeters]: 1.2cmx0.2cm..." On 6/2/13 at 3:18 PM, review of Resident #48's current care plans, received from the DON at this time, indicated "...[Resident's name] is at risk for falls d/t [due to] poor mobility, cellulitis of leg, right bka [below knee amputation], use of antidepressant, and Hx of CVA [cerebrovascular accident - stroke]...interventions: insure [sic] [Resident's name] is wearing non-skid shoes when transferring...date initiated: 11/26/2012...keep call light within easy reach and encourage [Resident's name] to use as needed...date initiated: 11/26/2012...Notify physician as needed...date initiated: 11/26/2012...PT [physical therapy] / OT [occupational therapy] as ordered...date initiated: 11/26/2012...Quarterly fall risk assessment...date initiated: 11/26/2012...Staff to assist with all transfers...date initiated:			

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	11/26/2012..." Interview with the DON at this time indicated she was unable to find where Resident's #48's care plan was updated to reflect this incident/fall. On 6/21/13 at 11:17 AM, review of the current "Accident and Supervision to Prevent Accidents" policy, received at this time from the DON, indicated "...Center evaluates the causal factors leading to a patient fall to help support relevant and consistent interventions to try to prevent occurrences. Proper actions following a fall include...revising the patient's plan of care...to reduce the likelihood of another fall..." On 6/21/13 at 2:57 PM, interview with the DON indicated the facility IDT (interdisciplinary team) talks about falls in the morning meeting and updates care plans as needed. The DON further indicated she was unsure why the care plans for Resident #105 and #48 were not updated and "...all care plans should be updated to reflect the most current fall...." 3.1-35(d)(2)(B)			

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F000323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to lock rooms containing potentially hazardous items. This potentially affect 88 residents with some type of mobility ability of 96 total residents. Findings included: On 6/17/13 at 7:35 p.m., an observation was made of the North Hall Storage closet and found to be unlocked. Upon opening the door it was observed to be littered with trash items, a metal folding chair was noted and wheelchair-foot-hardware was lying on the floor. The shelves were holding boxes of disposable gloves. On 6/17/13 at 7:36 p.m. & at 6/18/13 at 7:00 p.m., the biohazard room of the North Hall was found to be unlocked. A punch-type number system was observed on the outside of the door handle to the room. The door was ajar. Upon entry into the biohazard room, a hand spray-container of disinfectant was	F000323	F-323 Free of Accident/Hazards/Supervision/Devices I. How corrective action will be accomplished for those affected?North hall Storage closet, biohazards, electrical rooms, beauty shop doors were locked during the survey. II. How corrective action will be accomplished for those residents having potential to be affected. Residents who have some type of mobility are potentially affected by this. All doors that should be locked have been evaluated by maintenance director to ensure proper function. III. What measures will be put in place/systemic changes made to ensure correction. All doors that are required to be locked will have the locks and door closers evaluated by maintenance department to ensure proper function weekly. The Service provider for Audiology, Podiatry, Optometry, and Dental, have been inserviced on privacy and closing door while providing services, and locking door if leaving room unattended. IV. How the facility plans to monitor its performance to make sure that solutions are sustained.	07/22/2013

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	located in a lower cabinet that also was unlocked. The disinfectant had a warning label on the side indicating,"...keep out of the reach of children...." Red, bio-hazard plastic tub containers that were unlocked were also being stored. An unlocked red bin was observed to be full of biohazard waste in a red plastic bag. On 6/17/13 at 7:45 p.m., the door to the electrical storage room on the North Hall was unlocked. An observation was made of the contents of the electrical closet and found to include wires connecting into the walls and several fuse boxes unlocked located on the walls, an upright wheeled metal storage with drawers that could be easily pulled open; tools of trade; wire and metal shavings. There was not a sign indicating that the door should be locked. The inside of the door knob did nave a push/turn locking ability and the outside door knob had a key hole for entry and locking. On 6/17/13 at 7:55 p.m. & at 6/18/13 at 7:20 p.m., the biohazard room of the South Hall was found to be unlocked. A punch-type number system was observed on the outside of the door handle to the room. The door was ajar. Upon entry into the		Maintenance Director Audit Tool to be reviewed monthly x 6 months in Performance Improvement Meeting. Systemic changes will be completed by July 22, 2013	

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	biohazard room, a hand spray-container of disinfectant was located in a lower cabinet that also was unlocked. The disinfectant had a warning label on the side indicating,"...keep out of the reach of children..." Red, bio-hazard plastic tub containers that were unlocked were also being stored. It was also noted that a housekeeping scrub bucket on wheels was filled with a colored solution with a mop perched and soaking. On 6/19/13 at 10:50 a.m., an observation was made of the Beauty Shop room. The room door was opened wide and an observation was made of the audiologist equipment stacked to the right side of the room in gray tubs. An otoscope was noted to be lying on the equipment bins. An observation was made of the beauty shop supplies to be littered along the counter tops. The room was not occupied at this time. On 6/19/13 at 10:52 a.m., an interview was conducted with the Director of Nursing indicating that the Audiologist used the Beauty Shop for the residents exams. "...it's where they've done it ever since I've been here... yes, the Beauty Shop is locked when there isn't anyone in there to			

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	keep the residents safe...." On 6/21/13 from 2:00 p.m. until 4:00 p.m., an environmental tour was conducted with the Administrator, the Laundry/ Housekeeping Supervisor, the Maintenance Supervisor and the District Manager of the Contracted Services for Housekeeping and Laundry services. The following observations and interviews were conducted during this time of reference: At 2:35 p.m., an observation was made on the North Hall biohazard room. An interview with the Administrator indicated this room should always be locked due to the biohazard materials stored behind the door. It was observed to be unlocked upon observation. The contents inside the room were as described above in earlier notation. The Housekeeper/ Laundry Supervisor indicated that disinfectant hand held spray bottles should be stored behind a locked door. At 2:50 p.m., an observation was made of the North hall electrical storage room. An interview of the Maintenance Supervisor indicated that the door was to be locked at all times and should not be left unlocked			

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	due to the fact that items within the room could be harmful. The Administrator was interviewed and indicated only two keys existed; one for the Maintenance man and one by the Administrator. At 3:00 p.m. an observation was made of the Beauty Shop room. An interview with the Administrator indicated that the Beauty Shop was to be locked at all times when not occupied. At 3:20 p.m., an observation was made on the South Hall Biohazard room. An interview with the Administrator indicated this room should always be locked due to the biohazard materials stored behind the door. The contents inside the room were as described above in earlier notation. The Housekeeper/ Laundry Supervisor indicated that disinfectant hand held spray bottles should be stored behind a locked door. At 3:40 p.m., an observation was made of the South hall Electrical storage room. An interview with the Maintenance Supervisor indicated that the door was to be locked at all times and should not be left unlocked due to the fact that items within the room could be harmful.			

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KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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	On 6/22/13 at 4:00 p.m., record review were conducted as following: The Policy and Procedure titled, "General Environmental Conditions... 11. The physical plant and equipment are monitored through Performance Improvement (i.e., Preventative Maintenance Programs) for potential hazards. Hazards may include but are not limited to:... b. Disabled locks or latches,... g. improper storage and access to toxic chemicals,..." The Policy and Procedure titled, "Electrical Safety...10. Rooms containing electrical equipment with exposed (live) parts: a. locked, and b. Have entrances marked with conspicuous warning signs reading "Authorized Personnel Only." 3.1-45(a)(1)			

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F000328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview and record review, the facility failed to keep the oxygen room clean and orderly. This affected 1 of 1 oxygen storage rooms. Findings include: On 6/21/13 at 3:00 p.m., the oxygen storage room was observed along with the Administrator. It was observed to be approximately 10 feet by 9 feet, vented, locked, and labeled however, the contents of the oxygen room contained littered trash, a 5 shelved storage unit with varying items stored such as: the mechanical portion of a suction machine (there were 4 of these), 7 upright intravenous poles for using with peripheral intravenous fluids, 5 large liquid oxygen containers, several portable oxygen containers left lying on the floor, smaller green tank	F000328	F-328 Treatment of Care of Special Needs I. How corrective action will be accomplished for those affected?No residents were directly affected by this. II. How corrective action will be accomplished for those residents having potential to be affected. All residents are potentially affected. The oxygen room has been deep cleaned by housekeeping department and preventative maintenance checklist has been completed by maintenance department. Oxygen room placed on daily checklist for routine cleaning to ensure regulatory compliance. III. What measures will be put in place/systemic changes made to ensure correction. The oxygen room is scheduled to be deep cleaned by housekeeping department. Oxygen room placed on weekly checklist for routine cleaning. Housekeeping Supervisor will make rounds weekly to ensure oxygen room is clean.Preventative Maintenance	07/22/2013

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	oxygen tanks, portable oxygen tank holders, plastic bagged ambu-bags for artificial respiration provision yet this list is not complete. On 6/21/13 at 3:15 p.m., an interview was conducted with the Administrator indicating the deficit of knowledge of what the regulations were for oxygen storage. On 6/22/13 at 2:00 p.m., an interview was conducted with the Director of Nursing indicating that the Certified Nurses Aids (CNA) are responsible for refilling the portable oxygen tanks and they had not made anyone aware of the condition of the oxygen room. 3.1-47(a)(6)		checklist will be completed by maintenance department weekly. IV. How the facility plans to monitor its performance to make sure that solutions are sustained. Audit Tools to be completed monthly x 6 months in Performance Improvement Meeting. Systemic changes will be completed by July 22, 2013	

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F000371 SS=B	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to label and date consumable food in the unit nourishment refrigerators. This affected 2 of 2 nourishment refrigerators. Findings included: On 6/17/13 at 7:50 p.m., an observation was made of the North Hall Nourishment storage room. The refrigerator/ freezer unit was found to be dirty with a red, sticky fluid on the bottom shelf and spilled into the two storage drawers located at the bottom of the refrigerator. On 6/17/13 at 7:58 p.m., an observation was made of the South Hall Nourishment storage room. The refrigerator/ freezer unit was found to be dirty with littered crumbs on the bottom shelf. On 6/21/13 at 2:15 p.m., an observation of the North Hall	F000371	F-371 Food Procured/Stored/Prepared/Serve-Sanitary I. How corrective action will be accomplished for those affected? All food not properly labeled and dated in nourishment refrigerators was discarded and units cleaned. II. How corrective action will be accomplished for those residents having potential to be affected. Potentially all residents could be affected by this. Nutritional refrigerators have been cleaned. III. What measures will be put in place/systemic changes made to ensure correction. SDC will complete inservicing housekeeping, nursing and dietary staff on labeling, dating, and cleaning nourishment refrigerators. Housekeeping staff will clean	07/22/2013

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	Nourishment storage room with the Housekeeping and Laundry Supervisor indicating that the responsibility for keeping the Refrigerator/ Freezers clean was their own. The refrigerator was observed to have a red sticky fluid substance on the handles to the lower pull out drawers. An interview was conducted with the Housekeeping/ Laundry Supervisor indicating that the unit was in need of a cleaning. On 6/21/13 at 3:05 p.m.,an observation of the South Hall Nourishment storage room with the Housekeeping and Laundry Supervisor was completed. The refrigerator was observed to have crumbs littered on the bottom shelf and the door shelves were sticky. An interview was conducted with the Housekeeping/ Laundry Supervisor indicating that the unit was in need of a cleaning. 3.1-21(i)(3)		nourishment refrigerators daily. This will include discarding non marked and dated materials. IV. How the facility plans to monitor its performance to make sure that solutions are sustained. Housekeeping supervisor will make rounds 3 x weekly to ensure regulatory compliance. Audit Tool to be reviewed in Performance Improvement Meeting monthly x 6 months. Systemic changes will be completed by July 22, 2013	

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F000431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to keep a treatment cart locked while not occupied by professional staff. This deficiency	F000431	F-431 Drug Records, Label/Store Drugs and Biologicals I. How corrective action will be accomplished for those affected? Cart was locked during	07/22/2013

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	affected 1 of 1 treatment cart sampled. Findings included: On 6/21/13 at 3:30 p.m., a treatment cart was found to be unlocked on the North Hall outside of the T.V. Lounge. The top drawer was pulled and found to be unlocked. The content is the unlocked top drawer included had alcohol gel, scissors, varied care taking items for personal care such as tape and clean bandages. On 6/21/13 at 3:31 p.m., an interview was conducted with the Administrator indicating that the treatment carts are to be locked at all times when not in use by professional staff. On 6/22/13 at 10:00 a.m., an interview was conducted with the Director of Nursing indicating that the treatment carts are to be locked when a nurse is not by the cart. 3.1-25(m)		survey. II. How corrective action will be accomplished for those residents having potential to be affected. All residents with any degree of mobility are potentially affected by this. All med/treatment carts are currently locked when not attended by licensed personnel. III. What measures will be put in place/systemic changes made to ensure correction. Licensed nurses have been inserviced on policy and procedure related to locking of treatment carts. DNS or her designee will complete random audits 3x per week on all shifts. IV How the facility plans to monitor its performance to make sure that solutions are sustained. DNS or her designee will review audit tools during Performance Improvement Meeting monthly x 6 months. Systemic changes will be completed by July 22, 2013	

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F000456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview and record review, the facility failed to quality control the emergency crash carts and suction machine equipment for residents emergency usages. This affected 5 of 5 crash carts stocked with suction machine equipment. Findings included: On 6/17/13 at 7:00 p.m., an observation was made of a suction/ emergency crash cart to be located in the Lounge of the South Hall. Upon observation, it was indicated that the machine did not have directives for operation or a quality control log for the maintenance of the emergency equipment. On 6/21/13 at 3:00 p.m., an observation was made of the oxygen storage room located on the North Hall indicating the storage of the mechanical operational portion of the suction machines and the oxygen tanks for the emergency equipment. An interview was conducted with the	F000456	F- 456 Essential Equipment/Safe Operating Condition I. How corrective action will be accomplished for those affected? No residents were affected by this. II. How corrective action will be accomplished for those residents having potential to be affected. All residents requiring emergency interventions have the potential to be affected. Crash carts will be audited for quality control. III. What measures will be put in place/systemic changes made to ensure correction. Crash Cart audit will be completed by licensed nurses 3x per week to ensure quality control. Nurses have been inserviced on completing crash cart audit sheets. IV. How the facility plans to monitor its performance to make sure that solutions are sustained. DNS or her designee will review audit tools during Performance Improvement Meeting monthly x 6 months. Systemic changes will be completed by July 22, 2013	07/22/2013

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	Administrator at 3:15 p.m., indicating the deficit of knowledge of what suction machine and or oxygen storage regulations were and indicated the Director of Nursing (DON) would know. On 6/21/13 at 4:15 p.m., an interview was conducted with the DON indicating that the following locations were of the, "...emergency crash carts and the suction machine storage..." It was also indicated, "...we do use a lot of oxygen and we do have crash carts for the full code residents and we do not do quality control checks on the emergency equipment...." On 6/22/13 at 2:30 p.m. a Policy and Procedure was reviewed titled, " Suction Machine, Care and Use of. Rationale. Appropriate handling and care of suction machine prevents contamination, spread of infection and maintains the equipment in good working order...Procedure. 1. Before using the machine, check the following: a. Be sure all connections are tight at these points, ...b. make certain the rubber stopper is pressed firmly into secretion canister., c. Plug cord into outlet and switch on machine...." 3.1-19(bb)			

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F000465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain window coverings of a Residents room. This deficiency affected 1 of 96 residents. (Resident #79) Findings included: On 6/17/13 at 7:30 p.m. an observation was made of Room #108 and found to be missing the valance curtain on one side of the room occupied by Resident # 79. Upon closer observation it was observed to have a facility bed blanket hooked onto the c-hooks screwed into the header above the window to secure portions of the bed blanket in order for it to mock a curtain. Resident #79 is a totally dependent resident. On 6/21/13 at 3:15 p.m., an observation and interview was conducted with the Maintenance supervisor indicating that there had not been a work ordered completed for the repair of Room #108's window treatment. It was indicated that this was not appropriate and it would be fixed right away.	F000465	F- 465 Safe/Functional/Sanitary/Comfort able Environment I. How corrective action will be accomplished for those affected? The valance for room #108 has been replaced. II. How corrective action will be accomplished for those residents having potential to be affected. All residents have the potential to be affected. Resident rooms will be checked to ensure window coverings are maintained. Maintenance Director or his designee have audited all resident rooms for proper window treatments. III. What measures will be put in place/systemic changes made to ensure correction. Nursing staff and housekeeping have been inserviced on completion of work orders for maintenance issues. IV. How the facility plans to monitor its performance to make sure that solutions are sustained. Angel Care Checklist to be completed weekly by Guardian Angels to ensure window treatments are present, clean and in good repair ED or designee will review results in Performance Improvement Meeting monthly x 6 months. Systemic changes will be completed by July 22, 2013	07/22/2013

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